STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Maryland

Payment for Medical and Remedial Care and Services.

1. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

2. Payments for care or service will not exceed the amounts indicated in paragraphs 4, 5, 6, and 7 below and participation in the program will be limited to providers of service who accept as payment in full the amounts so paid.

3. The Single State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on cost of providing care or service, or fee plus cost of materials.

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4. Inpatient Hospital Services.

In 1977, The Maryland Medical Assistance Program was granted an initial waiver by the Department of Health, Education and Welfare (now the Department of Health and Human Services) in order to participate in a "hospital prospective rate setting experiment", wherein the Program would reimburse for inpatient hospital services at prospective rates reviewed and approved by the Maryland Health Services Cost Review Commission (HSCRC) instead of rates developed using principles contained in Federal and State regulations. The initial waiver was granted for a one-year period and has been renewed on a yearly basis. The most current waiver was issued in 1983.

A copy of the letter granting the initial waiver and a copy of the most current waiver are included in this Attachment as page 14, and pages 17-21.

a. All hospitals located in Maryland which participate in both the Program and the Medicare Experiment (under the aforementioned waiver), except those listed in 4 b. below, will charge and be reimbursed according to rates approved by the HSCRC, pursuant to HSCRC regulations, except that payment for approved administrative days will be according to: (1) A projected average Medicaid nursing home payment rate, or (2) If the hospital has a unit which is a skilled nursing facility, a rate which is the lesser of that described in (1) or the allowable cost in effect under Medicare for extended care services to patients of such unit. Under this system, all participating hospitals are required to submit data on base and budgeted years, using a uniform accounting and reporting system. Rates are approved for units of service in the various revenue

producing departments and are periodically adjusted for such items as inflation, volume changes, and pass-through costs. HSCRC rates are made pursuant to the uncompensated care methodology of the HSCRC rate setting system. This methodology is described at pages 2-A through 2-A.1 of this Attachment.

b. The Maryland Department of Health and Mental Hygiene [illegible] Maryland State-operated chronic, psychiatric, or tuberculosis facility.

c. An acute general or special hospital whose rates have not been established by the [illegible] Cost Review Commission will be reimbursed according to one of the following:

(1) The State will pay according to Medicare standards for reasonable costs [illegible] described in 42 CFR Part 413 or on the basis of charges or less than reasonable cost [illegible] inclusive rate providers that include provider based physician services, an average cost per day for provider based physician services will be developed and paid [illegible] retrospective cost reimbursement principles. In calculating retrospective cost reimbursement rates, the Department or its designee will deduct from the designated costs or groups of costs those restricted contributions which are designated by the donor for paying certain indirect operating costs, or groups of costs, or costs of specific groups of patients. When the cost, or group, or groups of costs, designated cover services rendered to all patients, including Medical Assistance recipients, operating costs applicable to all patients will be reduced by the amount of the restricted grants, gifts, or income from endowments thus resulting in a reduction of allowable costs. Payment for administrative days will be according to (1) A projected average Medicaid nursing home payment rate, or (2) If the hospital has a unit which is a skilled nursing facility, a rate which is the lesser of that described in (1) or the allowable costs in effect under Medicare for extended care services to patients of such unit.

Disproportionate Share Payments

A disproportionate share payment for hospitals serving a disproportionate share of low income patients (DSH) shall be implemented in the following manner:

A. A Maryland hospital shall be deemed a disproportionate share hospital for purposes of a disproportionate share payment if:

1. The hospital's Medicaid (Title XIX) inpatient utilization rate as defined in section 1923 (b) (2) is at least one standard deviation above the mean Medicaid (Title XIX) inpatient utilization rate for Maryland hospitals that are Medicaid providers; or

2. The hospital's low-income utilization rate, as defined in section 1923(b)(3), exceeds twenty-five percent (25%); and

3. The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetrical services to individuals who are entitled to Medical Assistance for such services under Maryland Medicaid's State Plan, except that the requirements of A(3) shall not apply to a hospital if:

a. Inpatients are predominantly individuals under 18 years of age; or
b. It did not provide non-emergency obstetric services as of December 22, 1987; and

4. The hospital's Medicaid inpatient utilization rate is not less than 1 percent.

B. Disproportionate Share Payments for Disproportionate Share Hospitals

1. For acute care general, free-standing chronic care, and free-standing pediatric-rehabilitation hospitals, the disproportionate share payment rate shall equal the minimum DSP required by federal law.

For these "types" of hospitals not governed by the Maryland Medicare Waiver, additional adjustment payments in the amount described above shall be made. For these "types" of hospitals governed by the Maryland Medicare Waiver, rates set in accordance with the Maryland Waiver already include the DSP, and no additional payment will be made.

2. a. For free-standing psychiatric hospitals with charity care inpatient costs exceeding 40 percent of total inpatient hospital costs, the disproportionate share payment shall equal the greater of: the hospital's annual "low income" costs (LI) divided by its annual inpatient Medicaid costs (MA), minus one, all multiplied by two, and then multiplied by its inpatient Medicaid payment (MAP) ((2(LI/MA)-1)x MAP); or the minimum DSP required by federal law.

b. For free-standing psychiatric hospitals with charity care inpatient costs less than or equal to 40 percent of total inpatient hospital costs, the disproportionate share payment shall equal the minimum DSP required by federal law.

c. For free-standing rehabilitation hospitals with charity care inpatient costs exceeding 20 percent of total inpatient hospital costs, the disproportionate share payment shall equal the greater of: the hospital's annual "low income" costs (LI) divided by its annual inpatient Medicaid Costs (MA), minus one, all multiplied by its inpatient medicaid payment (MAP)((LI/MA)-1)x MAP); or the minimum required by federal law.

d. For free-standing rehabiliation hospitals with charity care inpatient costs less than or equal to 20 percent of total inpatient hospital costs, the disproportionate share payment shall equal the minimum required by federal law.

Consistent with 42 U.S.C. 1396r-4, "low income" hospital costs equal the sum of (1) a hospital's inpatient Medicaid costs; (2) its state and local government inpatient cash subsidies; and (3) its charity care inpatient costs. Medicaid "costs" shall be deemed to equal Medicaid payments by the Medicaid program.

"Charity care inpatient costs" means hospital costs that are not reimbursed through any patient or third party reduced by the amount of gifts, restricted grants or income from endowments. Third party payments include Medicaid payments for the cost of care, but do not include disproportionate share payments.

"State and local government inpatient cash subsidies" means the payments for hospital costs from State or local government health agencies that are not intended as reimbursement for costs directly associated with particular patients, but are provided more generally for operating costs of the institution. Such subsidies do not include Medicaid payments or disproportionate share payments.

LI = Low income costs in most recent full fiscal year determined in advance of each fiscal year for FY 1994 and subsequent years. (For FY 1993, FY 1991 data will be used)

MA = Medical Assistance payments in most recent full fiscal year, determined in advance of each fiscal year for FY 1994 and subsequent years. (For FY 1993, FY 1991 will be used).

MAP = Medical Assistance payments in the fiscal year for which the DSP is being made.

One or more payments shall be made for each year which, in the aggregate, shall cover the entire fiscal year. DSH status and DSP depends on DSHs providing necessary qualifying information to the Department on a timely basis. DSP for any federal fiscal year are subject the DSH allotment set for Maryland.

DSP for a hospital will not exceed limits established in accordance with section 1923 (g) of the Social Security Act.

C. Additional payments will be made as determined in B. (above)

D. Out-of-State hospitals will be paid a disproportionate share adjustment as determined by the host state.

(2) Out-of-State hospitals designated as national referral centers for non-experimental organ transplant will be reimbursed the lesser of the Medicare DRG rate, 70% of charges, or the amount reimbursable by the host State's Title XIX Agency, for covered organ transplants.

(3) An Out-of-State hospital which is reimbursed under a prospective reimbursement methodology using diagnosis related groups or under a cost-related reimbursement methodology shall be reimbursed the lesser of its charges or the amount reimbursable by the host State's Title XIX agency. There shall be no year-end cost settlement.

(4) Reserved

(d) Infectious diseases,

(e) Pathology,

(f) Pharmacology,

(g) Pediatrics,

(h) Anesthesiology,

(i) Oncology,

(j) Psychiatry,

(k) Radiology, and

(l) Physical therapy;

(3) Be equipped with a tissue laboratory capable of tissue typing and immunological techniques;

(4) Be capable of supplying large quantities of blood on short notice; and

(5) For liver transplantations, have performed at least twelve similar procedures in the preceding twelve months;

(6) For heart and heart-lung transplantations, be a currently approved Medicare provider for heart transplantations.

(b) Out-of-State hospitals designated as national referral centers for non-experimental organ transplants will be reimbursed the lesser of the Medicare DRG rate, 70% of charges, or the amount reimbursable by the host State's Title XIX Agency, for covered organ transplants.

(3) An out-of-State hospital which is reimbursed under a prospective reimbursement methodology using diagnosis related groups shall be reimbursed the lesser of its charges or the amount reimbursable by the host state's Title XIX agency. There shall be no year-end cost settlement.

(4) An out-of-State hospital which is reimbursed under a cost-related reimbursement methodology shall be reimbursed the lesser of its charges or the amount reimbursable by the host state's Title XIX agency. There shall be no year-end cost settlement.

(5) An out-of-State hospital licensed special-rehabilitation, except a hospital located in the District of Columbia, shall be reimbursed the lesser of its charges: or (i) the amount reimbursable by the host state's Title XIX agency; (ii) if the host state Title XIX agency does not cover inpatient rehabilitation hospital services, the amount reimbursable by the Title XVIII intermediary; or if (i) or (ii) are not applicable, the rate of reimbursement will be determined in accordance with Medicare standards and principles for retrospective cost reimbursement.

(6) For each hospital not participating in the Title XVIII Program, the State will apply the standards and principles described in 42 CFR Part 482.

(7) Medicare standards and principles are modified to apply the limits established by the Secretary of Health and Human Services under 42 CFR 413.30.

(8) The State will provide for a system to assure that claims by providers for reimbursement for inpatient hospital services meet requirements.

(9) A hospital located in the District of Columbia shall be paid a percentage of charges based on the result of multiplying the following four factors, A-D.

A. Factor 1 is the report period cost-to-charge ratio. This factor, which is determined by an analysis of the hospital's most recent cost report performed by the Maryland Medical Assistance Program or its designee, establishes the cost-to-charge ratio for the hospital during the cost report period.

B. Factor 2 is the cost-to-charge projection ratio. This factor, which is determined by an analysis of the hospital's two most recent cost reports performed by the Maryland Medical Assistance Program or its designee, projects the cost-to-charge ratio from the cost report period to the payment period. The annual rate of change is applied from the mid-point of the report period used to develop Factor 1 to the mid-point of the prospective payment period. To reflect the accelerating pace of cost-to-charge ratio decreases, Factor 2 shall not be greater than 1.000.

$$Factor2 = \left(\sqrt[c]{B/A}\right)^{d}$$

A = cost to charge ratio, date 1
B = cost to charge ratio, date 2
c = # of days between date 1 and date 2
d = # of days between date 2 and end of rate year

For example:
6/30/89 C-T-C is .6476
6/30/90 C-T-C is .5240
365 days between 6/30/89 and 6/30/90
Rate year end is 6/30/93, or 1,096 days between date 2 and rate year end

$$\left(\sqrt[365]{.5240/.6476}\right)^{1096} = .529446$$

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C. Factor 3 is the efficiency and economy adjustment. This factor represents the fraction of the hospital's costs which the MMAP finds to be efficiently and economically incurred. In making this finding, the MMAP compares the hospital's cost of providing care to program recipients classified into DRG/age categories with the costs of providing care to identically classified program recipients in Maryland hospitals. In order to recognize the possibility that the severity of illness within DRG/age categories may be greater for program recipients treated in D.C. hospitals than in Maryland hospitals, the MMAP will adjust cost differences for positive DRG/age adjusted length-of-stay (LOS) differences between the hospital and the Maryland LOS. For hospitals other than the National Rehabilitation Hospital, the MMAP shall give 80% credit for positive LOS differences because for DRGs other than 462 (Rehabilitation) the cost of longer stay days is approximately 30% of the cost of average days. For the National Rehabilitation Hospital, the MMAP shall give 100% credit for the positive LOS difference because in DRG 462 the cost of longer stay days equals the cost of an average day.

Costs of D.C. hospitals used in the above comparison are adjusted to reflect labor market differences between D.C. hospitals and Maryland hospitals as a ratio, based upon adjusted information as supplied in Hospital Statistics issued by the American Hospital Association as applied to the percentage of D.C. hospital costs which are labor expenses. If cumulative information starting from 1989 as supplied in Hospital Statistics reveals that the:

(a) Cumulative D.C. labor costs increase per full time equivalent (FTE) is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is greater than the cumulative increase in Average Hourly Earnings, Hospital Workers (AHE) as reported by the Bureau of Labor Statistics, then the Program will use information as supplied in the 1990-1991 edition of Hospital Statistics; or if,

(b) Cumulative D.C. labor cost increase per FTE is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is less than the cumulative increase in AHE, then the 1989 data supplied in the 1990-1991 edition of Hospital Statistics will be adjusted to recognize the portion of the D.C. increase in labor cost per FTE which does not exceed the cumulative AHE; or if

(c) Cumulative D.C. labor cost increase per FTE is less than the cumulative Maryland labor cost increase per FTE in any edition of Hospital Statistics, then the labor market difference shall be measured using that current issue of Hospital Statistics.